advice on employment? As to security of records, why should Dr David feel that his office is any more secure than school medical offices?

If there was more co-operation between general practitioners, hospitals, and local authorities there would be no need for copies of letters to be circulated all around the area.

P MARTIN

Chorleywood, Herts

The principle of coterminosity and the NHS

SIR,—I am sure most of your readers were either fascinated or flummoxed to be told in a recent leading article (24 June, p 1652) that most NHS staff were disenchanted with "the principle of coterminosity" when interviewed in regard to their views on the 1974 NHS reorganisation. It is common ground that this reorganisation has been generally disastrous and it is right that the BMA should debate its consequences—but please in language that ordinary mortals can comprehend. I asked 10 doctors including our dean (Cambridge First) and several intelligent administrative staff at our institute what they thought was meant by "coterminosity" or let alone the "principle of coterminosity." None had the slightest idea, nor, may I add, does any up-to-date dictionary, including the massive *Shorter Oxford English Dictionary*, throw any light. If the mandarins of the Department of Health and Social Security and their minions must communicate with each other in fancy jargon there is no need for *BMJ* editorial writers to follow suit. If perforce reference to this or a similar term is really unavoidable when debating ministerial documents surely as a matter of courtesy to the poor readers there should be clarifying definitions or explanations. Normally, I might add, the *BMJ* editorials on clinical matters are models of lucidity.

E WILSON JONES

Department of Histopathology,
Institute of Dermatology,
London WC2

* "Coterminous" means "sharing the same boundaries." One of the basic concepts of the reorganisation of the NHS was that the areas should be the same geographical units as the new units of local government after its reorganisation. *Chambers Twentieth Century Dictionary* and the *Concise Oxford Dictionary* prefer the spelling "conterminous," but both words appear in each.—Ed, *BMJ*.

General practice records

SIR,—I was glad to see that Sir Francis Avery Jones included support for medical records in hospitals and in general practice among his priorities for reform (1 July, p 5).

Accurate, structured records are not only the chief practical means of auditing quality: they are also the way that we may individually perceive and correct our errors. Slovenly and incomplete records in general practice, like episodic fragments in hospital records, are costly in duplicated investigation and lead to a multiplication of technically orientated tactics without any co-ordinated strategy, but they have one great virtue which ensures that they will grow like weeds in the absence of effort to

root them out: they conceal from us the consequences of our errors.

We need support in a material form. A4 records may not be essential to all good practice and there may be other ways of ensuring that for every patient there is a brief summary of major history and previous investigations at the front of the record, that hospital correspondence is filed unfolded in date order, and that clinical notes can be full enough to ensure that what is not entered has not been done. But surely there should be some support and encouragement for more general practitioners to embark on A4 conversion if they are prepared to work at the new level that this will permit. Training practices should at least have an option to operate such records, and some effort should be made to bring together the experience of users and share this with their colleagues.

For several years no new practices have been able to convert to A4, nor have any of the pioneers of the new records had any assistance in the onerous work of conversion and housing; all that has ever been provided is the stationery, and there are still practices today in a state of half-conversion, unable to complete because of an end to supplies and the complete lack of interest shown by the Department of Health and Social Security for a venture which is originally supported with enthusiasm.

Good records mean more work, albeit more rational and effective. The DHSS policy of cowardly acquiescence in a stagnation only too easy in general practice will prove more and more costly as medical decisions acquire a larger technical potential. Good decisions are based on good records plus sufficient consultation time to think rather than just act. Good records are not only a measure of good practice; they are a precondition for it.

An absolute minimum start would be an assisted conference of A4 users, with real attention to its discussions and conclusions. What about it?

JULIAN TUDOR HART

Glyncorrwg,
nr Port Talbot, W Glamorgan

Out-of-hours use of clinical pathologists

SIR,—One feature of NHS money-saving to the detriment of junior doctors has not, I feel, been publicised sufficiently. I refer to the practice of using clinical pathologists instead of technicians to perform out-of-hours emergency investigations.

I have recently completed two years as a junior pathologist in a teaching hospital, during which time I worked a one-in-five rota on duty for the laboratory—a most unsatisfactory pastime, as one's medical training is hardly stretched by performing white cell counts or blood sugars. The hospital concerned could not offer overtime to applicants for technical posts, and as a result of this there were hardly any technicians who were trained in the emergency procedures and could then provide cover when any of the pathologists were on leave. I am now a second-year registrar in clinical haematology in a large district hospital; in the department are at least 14 technicians who, presumably for financial reasons, are very keen to do as much on-call as possible. Unfortunately, so far as the hospital budget is concerned the Whitley Council £4.55 per visit for technicians does not compare favourably with my munificent 77p per hour for the same work. Thus I have

to do technical work for the equivalent of one weekend in every four, and I have narrowly avoided being put on duty for laboratory work on weekday nights as well. For a weekend on duty I receive £36.96 before deductions; a technician on call for a Sunday alone can expect to earn anything between £40 and £130, the latter being the more accurate, as this is a very busy hospital.

I am happy to fulfil my present clinical on-call obligations. I am at least then doing work I enjoy and am trained for, and the pay for which, albeit dismal, is the same as that of my medical colleagues. I am most unhappy to do work that I do not enjoy, am not properly trained for, and for which the technical staff are paid, at their busiest, seven times as much. Technical on-call work has always been put forward as a privilege for junior pathologists. Why is this? I would be interested to hear of any surgical registrars who are on call to sterilise instruments, radiology registrars who are on call to take emergency chest x-rays, medical registrars who provide an out-of-hours physiotherapy service, etc. I have no wish to see any reduction in on-call pay for technicians. I would merely question the morality of forcing doctors to do paramedical work for what seems to me to be the sole reason of financial expediency. It is important for the pathologist to be able to do some of the technical work in his laboratory, but cannot the mechanisms of, say, the Coulter counter be mastered better at lunch-time than at 5 am on a Sunday morning?

ANOTHER DISILLUSIONED
JUNIOR DOCTOR

London

Registrar redistribution

SIR,—Many of your readers may not be aware of the practical implications of a registrar redistribution exercise (Mark II version) currently in progress under the auspices of the Central Manpower Committee and affecting the specialty of obstetrics and gynaecology but planned later to include all specialties. Although superficially any exercise aimed at correcting maldistribution obviously merits support, there are some rather important sequelae which may well outweigh the apparent advantages of the whole operation, and especially so when one is aware of the failure of its predecessor, which was specifically aimed at redistributing some 500 registrar posts from teaching hospitals to the periphery.

(1) This particular redistribution exercise appears to contravene certain agreed safeguards in the Second Progress Report of 1971¹—namely, that staffing discrepancies "will not be solved by direction of labour, whether individual or by any system of block allocations to regions," and furthermore that "the nature of consultant work will not be changed and the standard required for appointment to a consultant post will be maintained."

(2) The CMC formula for redistribution is based solely on the crude geographical population and nothing else, and there is a heavy statistical bias in favour of the teaching hospital staff. More practical and sensitive parameters such as current work load (new outpatients and deaths and discharges), waiting lists (outpatient and inpatient), and the existing staffing ratios appear to have been completely disregarded.

(3) It appears to be tacitly accepted that the regional manpower committees should automatically rubber-stamp the CMC's decision,

though they are given some discretion to handle the redistribution as they think best.

(4) The repercussions on postgraduate training and teaching, especially in the regional or peripheral hospitals, have been completely ignored, and the local consultants, as usual, are left to salvage what they can out of the resulting chaos.

I feel that it is most important that colleagues in our NHS hospitals should have an opportunity to express their views on an important matter such as this before we are all presented with the usual fait accompli. I would like respectfully to submit that the current staffing inequalities and chaos can be solved only by a radical rethink of the whole problem instead of tinkering with the tip of the iceberg.

G I B DA COSTA

Shotley Bridge General Hospital,
Consett, Co Durham

¹ Hospital Staffing Structure (Medical and Dental):
Second Progress Report, *British Medical Journal*
Supplement, 1971, 3, 119.

New consultant contract

SIR,—In your leading article "Proceed with the pricing" (1 July, p 4) you state that the result of the ballot on the new contract "confirms the favourable reception given . . . at the countrywide meetings of consultants addressed by the chairman [of the Central Committee for Hospital Medical Services] and his senior colleagues." This is hardly surprising if the meeting held at BMA House was typical. The views expressed from the platform were so favourable and enthusiastic (some might even say one-sided) that many consultants were bound to leave the Great Hall with the feeling that a new dawn was about to break. It is therefore a matter of concern that an adequate presentation of the drawbacks and pitfalls in the proposals (such as that by Mr T McFarlane (17 June, p 1647)) did not appear in your columns until the ballot had closed.

Let us be under no illusions: the majority of consultants and senior registrars were wearing rose-tinted spectacles when they completed their ballot papers.

W J HARRISON

North Middlesex Hospital,
London N18

*.*The virtues and shortcomings of the new contract were discussed at considerable length in our correspondence columns during the period leading up to the ballot.—Ed, *BMJ*.

Future of British anaesthetics

SIR,—Dr Ian Hine (1 July, p 60) has been upset by my comments, but if he were to think deeply on the subject he might realise that I want to improve the status and job satisfaction of consultant anaesthetists in Britain by relieving them of the routine anaesthetic so that their very hard-learned experience and training can be used (1) in those difficult cases where they are needed, (2) in the intensive care unit, and (3) in the accident department. That is, so that they become what in fact they are, consultants in emergency medicine.

If they relegate their more mundane work to people like me (who would enjoy it enormously), then they would truly become what they are capable of being: the most

demanding and exciting specialty of all hospital medicine.

D C HOGG

Bristol

A solution for preclinical departments

SIR,—A further way in which parity can be achieved between clinical and preclinical medical teachers (Dr B R MacKenna, 1 July, p 72) is to pay them for their involvement in clinical teaching. This participation could be increased with benefit to the patient, the student, and the clinician.

Eight years ago I had the task of re-organising the final-year clinical curriculum in the Liverpool Medical School. I sought the help of the preclinical teachers who attended regular weekly student seminars with the clinicians in the hospital. On one occasion a man of 32 with a lump in his neck and hypertrophied rugae who complained of passing bright red blood per rectum puzzled the assembled clinicians. Bronchoscopy and gastroscopy were not helpful. The physiologist present, Professor R A Gregory, thought he had a malignant gastrinoma attached to his transverse colon and hoped to confirm it by an estimation of his serum gastrin concentration, which he could get done in America. Of course it was confirmed and the patient's management greatly assisted. When the patient died about 18 months later at a weekend, Professor Gregory himself recovered the tumour. He and his preclinical colleagues received, and as far as I know still receive, no remuneration for these seminars extending into the early evening. He could not at that time get the necessary money to enable him to estimate the serum gastrin, although he synthesised gastrin and could make a clinical diagnosis.

Surely the time has come to recognise the important contribution of medically qualified preclinical teachers to medical education and to broaden the conception of their role in patient care. A way must be found to reward their talents and recognise real distinction in so numerically small a number of our profession.

JAMES MORONEY

Baldrine, IOM

SIR,—I read with interest Dr B R MacKenna's article (1 July, p 72). The idea deserves careful consideration, but I feel that I must point out an inaccuracy. He writes, when considering non-medically qualified staff, "It would be iniquitous for two groups doing the same job in the same department to be placed on different salary scales."

Medically qualified staff are required in many preclinical departments to bear clinical responsibility in a number of ways: (a) for medical students in the performance upon each other of physiological procedures, which experiments form an essential part of the undergraduate curriculum; (b) for patients sent from hospital, without hospital medical staff in attendance, for investigative physiological tests; (c) for human subjects in physiological research. ASTMS insists that medically qualified staff be to hand so that its members will never be called upon to take responsibility in an emergency.

Taking all this into consideration it is clear that for many departments Dr MacKenna's assertion is false. Medically qualified staff

are, in these departments, called upon not only to fulfil teaching and research commitments but also to perform tasks which require medical registration and membership of a medical defence organisation.

W S MONKHOUSE
Nottingham Preclinical
Representative to the
Conference of Medical
Academic Staff

Department of Human Morphology,
University Hospital and Medical
School,
Nottingham

Item-of-service payments to general practitioners

SIR,—I wonder whether you can tell me whether the BMA has ever attempted to persuade the Department of Health and Social Security to pay general practitioners for two very important items of service—namely, electrocardiograms and pregnancy tests.

Over the years general practitioners must have saved the DHSS many thousands of pounds by doing ECGs for no direct reimbursement on machines owned by themselves and using paper paid for by themselves. The callous acceptance of this state of affairs by successive Ministers of Health seems to me to be typical of the cheap and shoddy way the NHS is run.

That it is also very inefficient is perhaps more important, because I am sure many more GPs would do ECGs on their own machines if a realistic charge could be made either to the patient or to the DHSS. Similarly I am sure many GPs would do pregnancy tests for their patients if they could be reimbursed their costs. It seems odd that pharmacists in a private capacity can charge patients for doing these tests whereas the patient's own doctor has to refuse to do the test. The latter could be done at the initial consultation, so saving the patient considerable trouble and possibly travelling expenses also in the case of rural patients.

Why is this ridiculous state of affairs allowed to continue?

J P H ANDERSON

Lakenheath, Suffolk

*.*The Secretary writes: "The extension of item-of-service payments to cover these and other services provided by general practitioners has been pursued with the Health Departments on a number of occasions in recent years. The Departments have been extremely reluctant to agree to any extension of the range of item-of-service payments in general practice, but this is a question which is currently being studied by the New Charter Working Group of the General Medical Services Committee."—Ed, *BMJ*.

Unfinished business

SIR,—Am I alone among the grass roots of the Association in finding, with occasional exceptions, the Annual Report of Council (22 April, p 1065) lacking in urgency and relevance? In the theatre of yesteryear we waited for Godot and I feel the Association is waiting for the 1979 Review Body and the Royal Commission.

Why can't the BMA start discussions on the abolition of multidistrict areas as agreed by the Representative Body in Motion 239